ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services

Program Development & Quality Assurance

P.O. Box 1437, Slot S-295 · Little Rock, AR 72203-1437
501-682-8368 · Fax: 501-682-2480

TO: **Arkansas Medicaid Health Care Providers – All Providers**

DATE: **February 1, 2013**

SUBJECT: **Provider Manual Update Transmittal EPISODE-1-12**

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
____	____	213.000	2-1-13
____	____	213.100	2-1-13
____	____	213.200	2-1-13
____	____	213.300	2-1-13
____	____	213.400	2-1-13
____	____	213.500	2-1-13
____	____	213.600	2-1-13
____	____	213.700	2-1-13
____	____	214.000	2-1-13
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____	____	214.600	2-1-13
____	____	214.700	2-1-13

Explanation of Updates

Sections 213.000, 213.100, 213.200, 213.300, 213.400, 213.500, 213.600, and 213.700 are new sections with information pertaining to the Congestive Heart Failure (CHF) episode of care.

Sections 214.000, 214.100, 214.200, 214.300, 214.400, 214.500, 214.600, and 214.700 are new sections with information pertaining to the Total Joint Replacement episode of care.

The paper version of this update transmittal includes revised pages that may be filed in your provider manual. See Section I for instructions on updating the paper version of the manual. For electronic versions, these changes have already been incorporated.

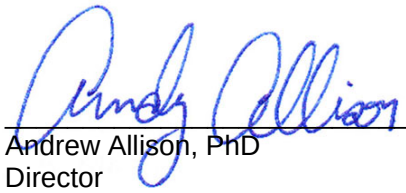
If you have questions regarding this transmittal, please contact the Arkansas Payment Improvement Initiative Center at 1-866-322-4696 (Toll-Free) within Arkansas or locally and Out-of-State at (501) 301-8311.

If you need this material in an alternative format, such as large print, please contact our Americans with Disabilities Act Coordinator at 501-682-6453 (Local); 1-800-482-5850, extension 2-6453 (Toll-

Free) or to obtain access to these numbers through voice relay, 1-800-877-8973 (TTY Hearing Impaired).

Arkansas Medicaid provider manuals (including update transmittals), official notices, notices of rule making and remittance advice (RA) messages are available for downloading from the Arkansas Medicaid website: www.medicaid.state.ar.us.

Thank you for your participation in the Arkansas Medicaid Program.



Andrew Allison, PhD
Director

SECTION II – EPISODES OF CARE
CONTENTS

213.000 CONGESTIVE HEART FAILURE (CHF) EPISODES

213.100 Episode Definition/Scope of Services 2-1-13

A. *Episode subtypes:* There are no subtypes for this episode type.

B. *Episode trigger:* Inpatient admission with a primary diagnosis code for heart failure

C. *Episode duration:* Episodes begin at inpatient admission for heart failure. Episodes end at the latter of 30 days after the date of discharge for the triggering admission or the date of discharge for any inpatient readmission initiated within 30 days of the initial discharge. Episodes shall not exceed 45 days post-discharge from the triggering admission.

D. *Episode services:* The episode will include all of the following services rendered within the episode's duration:

1. Inpatient facility and professional fees for the initial hospitalization and for all cause readmissions
2. Emergency or observation care
3. Home health services
4. Skilled nursing facility care due to acute exacerbation of CHF (services not included in episode for patients with SNF care in 30 days prior to episode start)
5. Durable medical equipment

213.200 Principal Accountable Provider 2-1-13

The Principal Accountable Provider (PAP) for an episode is the admitting hospital for the trigger hospitalization.

213.300 Exclusions 2-1-13

Episodes meeting one or more of the following criteria will be excluded:

A. Beneficiaries do not have continuous Medicaid enrollment for the duration of the episode

B. Beneficiaries under the age of 18 at the time of admission

C. Beneficiaries with any cause inpatient stay in the 30 days prior to the triggering admission

D. Beneficiaries with any of the following comorbidities diagnosed in the period beginning 365 days before the episode start date and concluding on the episode end date: 1) End-Stage Renal Disease; 2) organ transplants; 3) pregnancy; 4) mechanical or left ventricular assist device (LVAD); 5) intra-aortic balloon pump (IABP)

E. Beneficiaries with diagnoses for malignant cancers in the period beginning 365 days before the episode start date and concluding on the episode end date. The following types of cancers will not be criteria for episode exclusion: colon, rectum, skin, female breast, cervix uteri, body of uterus, prostate, testes, bladder, lymph nodes, lymphoid leukemia, monocytic leukemia.

F. Beneficiaries who received a pacemaker or cardiac defibrillator in 6 months prior to the start of the episode or during the episode

G. Beneficiaries with any of the following statuses upon discharge: 1) transferred to acute care or inpatient psych facility; 2) left against medical advice; 3) expired

213.400 Adjustments 2-1-13

No adjustments are included in this episode type.

213.500 Quality Measures 2-1-13

A. *Quality measures "to pass":*

1. Percent of patients with LVSD who are prescribed an ACEI or ARB at hospital discharge – must meet minimum threshold of 85%.

B. *Quality measures "to track":*

1. Frequency of outpatient follow-ups within 7 and 14 days after discharge
2. For qualitative assessments of left ventricular ejection fraction (LVEF), proportion of patients matching: hyperdynamic, normal, mild dysfunction, moderate dysfunction, severe dysfunction
3. Average quantitative ejection fraction value
4. 30-day all cause readmission rate
5. 30-day heart failure readmission rate
6. 30-day outpatient observation care rate – utilization metric

The following quality measures require providers to submit data through the provider portal: qualitative assessment of LVEF, average quantitative ejection fraction value.

213.600 Thresholds for Incentive Payments 2-1-13

A. The acceptable threshold is $6,644.

B. The commendable threshold is $4,722.

C. The gain sharing limit is $3,263.

D. The gain sharing percentage is 50%.

E. The risk sharing percentage is 50%.

213.700 Minimum Case Volume 2-1-13

The minimum case volume is 5 total cases per 12-month period.

214.000 TOTAL JOINT REPLACEMENT EPISODES

214.100 Episode Definition/Scope of Services 2-1-13

A. *Episode subtypes:* There are no subtypes for this episode type.

B. *Episode trigger:* A surgical procedure for total hip replacement or total knee replacement

C. *Episode duration:* Episodes begin 30 days prior to the date of admission for the inpatient hospitalization for the total joint replacement surgery and end 90 days after the date of discharge.

D. *Episode services:* The following services are included in the episode:

1. From 30 days prior to the date of admission to the date of the surgery: All evaluation and management, hip- or knee-related radiology and all labs/imaging/other outpatient services
2. During the triggering procedure: all medical, inpatient and outpatient services
3. From the date of the surgery to 30 days after the date of discharge: All cause readmissions, non-traumatic revisions, complications, all follow-up evaluation & management, all emergency services, all home health and therapy, hip/knee radiology and all labs/imaging/other outpatient procedures
4. From 31 days to 90 days after the date of discharge: Readmissions due to infections and complications as well as hip or knee-related follow-up evaluation and management, home health and therapy and labs/imaging/other outpatient procedures

214.200 Principal Accountable Provider 2-1-13

For each episode, the Principal Accountable Provider (PAP) is the orthopedic surgeon performing the total joint replacement procedure.

214.300 Exclusions 2-1-13

Episodes meeting one or more of the following criteria will be excluded:

A. Beneficiaries who are under the age of 18 at the time of admission

B. Beneficiaries with the following comorbidities diagnosed in the period beginning 365 days before the episode start date and concluding on the date of admission for the joint replacement surgery: 1) select autoimmune diseases; 2) HIV; 3) End-Stage Renal Disease; 4) liver, kidney, heart, or lung transplants; 5) pregnancy; 6) sickle cell disease; 7) fractures, dislocations, open wounds, and/or trauma

C. Beneficiaries with any of the following statuses upon discharge: 1) left against medical advice; 2) expired during hospital stay

D. Beneficiaries who do not have continuous Medicaid enrollment for the duration of the episode

214.400 Adjustments 2-1-13

For the purposes of determining a PAP's performance, the total reimbursement attributable to the PAP is adjusted for total joint replacement episodes involving a knee replacement to reflect that knee replacements have higher average costs than hip replacements. Over time, Medicaid may add or subtract risk or severity factors in line with new research and/or empirical evidence.

214.500 Quality Measures 2-1-13

A. *Quality measures "to track":*

1. 30-day, all cause readmission rate
2. Frequency of use of prophylaxis against post-op Deep Venous Thrombosis (DVT)/Pulmonary Embolism (PE) (pharmacologic or mechanical compression)
2. Frequency of post-op DVT/PE
3. 30-day wound infection rate

The following quality measures require providers to submit data through the provider portal: use of prophylaxis against post-op Deep Venous Thrombosis (DVT)/Pulmonary Embolism (PE), occurrence of post-op Deep Venous Thrombosis (DVT)/Pulmonary Embolism (PE)

214.600 Thresholds for Incentive Payments 2-1-13

A. The acceptable threshold is $12,469.

B. The commendable threshold is $8,098.

C. The gain sharing limit is $5,249.

D. The gain sharing percentage is 50%.

E. The risk sharing percentage is 50%.

214.700 Minimum Case Volume 2-1-13

The minimum case volume is 5 total cases per 12-month period.

1. Inpatient Hospital Services (continued)

A. INCENTIVES TO IMPROVE CARE QUALITY, EFFICIENCY, AND ECONOMY (CONTINUED)

V. APPLICATION: Complete details including technical information regarding specific quality and reporting metrics, performance thresholds and incentive adjustments are available in the Episodes of Care Medicaid Manual available at https://www.medicaid.state.ar.us/InternetSolution/Provider/docs/docs.aspx and also at the Arkansas Health Care Payment Improvement Initiative website at http://www.paymentinitiative.org/Pages/default.aspx.

Effective for dates of service on or after October 1, 2012, the defined scope of services within the following episode(s) of care are subject to incentive adjustments:

(1) **Perinatal Care Episodes**

Effective for dates of service on or after February 1, 2013, the defined scope of services within the following episode(s) of care are subject to incentive adjustments:

(1) **Congestive Heart Failure (CHF) Episodes**
(2) **Total Joint Replacement Episodes**

2.a. Outpatient Hospital Services (continued)

A. INCENTIVES TO IMPROVE CARE QUALITY, EFFICIENCY, AND ECONOMY (CONTINUED)

V. APPLICATION: Complete details including technical information regarding specific quality and reporting metrics, performance thresholds and incentive adjustments are available in the Episodes of Care Medicaid Manual available at https://www.medicaid.state.ar.us/InternetSolution/Provider/docs/docs.aspx and also at the Arkansas Health Care Payment Improvement Initiative website at http://www.paymentinitiative.org/Pages/default.aspx.

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(1) **Perinatal Care Episodes**

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(1) **Congestive Heart Failure (CHF) Episodes**
(2) **Total Joint Replacement Episodes**

5. Physicians' Services (continued)

A. INCENTIVES TO IMPROVE CARE QUALITY, EFFICIENCY, AND ECONOMY (CONTINUED)

V. APPLICATION: Complete details including technical information regarding specific quality and reporting metrics, performance thresholds and incentive adjustments are available in the Episodes of Care Medicaid Manual available at https://www.medicaid.state.ar.us/InternetSolution/Provider/docs/docs.aspx and also at the Arkansas Health Care Payment Improvement Initiative website at http://www.paymentinitiative.org/Pages/default.aspx.

Effective for dates of service on or after October 1, 2012, the defined scope of services within the following episode(s) of care are subject to incentive adjustments:

(1) **Acute Ambulatory Upper Respiratory Infection (URI) Episodes**
(2) **Perinatal Care Episodes**
(3) **Attention Deficit Hyperactivity Disorder (ADHD) Episodes**

Effective for dates of service on or after February 1, 2013, the defined scope of services within the following episode(s) of care are subject to incentive adjustments:

(1) **Congestive Heart Failure (CHF) Episodes**
(2) **Total Joint Replacement Episodes**

23. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary. (Continued)

e. Emergency Hospital Services (Continued)

A. INCENTIVES TO IMPROVE CARE QUALITY, EFFICIENCY, AND ECONOMY (CONTINUED)

V. APPLICATION: Complete details including technical information regarding specific quality and reporting metrics, performance thresholds and incentive adjustments are available in the Episodes of Care Medicaid Manual available at https://www.medicaid.state.ar.us/InternetSolution/Provider/docs/docs.aspx and also at the Arkansas Health Care Payment Improvement Initiative website at http://www.paymentinitiative.org/Pages/default.aspx.

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(1) **Congestive Heart Failure (CHF) Episodes**

23. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary. (Continued)

f. Critical Access Hospitals (CAH) (continued)

A. INCENTIVES TO IMPROVE CARE QUALITY, EFFICIENCY, AND ECONOMY (CONTINUED)

V. APPLICATION: Complete details including technical information regarding specific quality and reporting metrics, performance thresholds and incentive adjustments are available in the Episodes of Care Medicaid Manual available at https://www.medicaid.state.ar.us/InternetSolution/Provider/docs/docs.aspx and also at the Arkansas Health Care Payment Improvement Initiative website at http://www.paymentinitiative.org/Pages/default.aspx.

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(1) **Congestive Heart Failure (CHF) Episodes**